ADA Block No.	*ADA Description Alabama Medicaid Use*	*Guidelines*
2	Preauthorization Number	Enter the 10 digit Prior Authorization Number (if applicable)
4-11	Other Coverage/Other Insurance Information (These blocks are only required if patient has other insurance.)	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Subscriber Identifier (SSN or ID#) Enter the Other Insurance Policy Number • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code
12	Primary Insured Information (Medicaid Recipient Information)	Enter name as Last, First. Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID you enter in Block 15.** If a recipient has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe, A B" with no punctuation. For recipient D'Andre Doe, enter "Doe, D'Andre" with an apostrophe and no spaces.
15	Subscriber Identifier (SSN/ID#)/Medicaid Number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
24	Procedure Date/Date of Service (MM/DD/CCYY)	Enter numerically (MM/DD/YY) the date of service for each procedure provided.
25	Area of the Oral Cavity/Oral Cavity Designation	If applicable, enter the Oral Cavity Designation Code associated with the procedure being performed on a specific tooth. 00 —Full Mouth 01 —Upper Arch 02 —Lower Arch 09 —Other Area of Oral Cavity 10 —Upper Right Quadrant 20 —Upper Left Quadrant 30 —Lower Left Quadrant 40 —Lower Right Quadrant L —Left R—Right There are few procdures that require an oral cavity designation. Some of these include D4341, D4355, D4910, D7970 and D7971.
27	Tooth Number or Letter	Enter the appropriate tooth number for permanent teeth (01-34) or the appropriate letter for primary teeth (A-T) as indicated on the claim form. Enter AS – TS for children and 51-82 for adults for all supernumerary teeth regardless of location in maxilla or mandible. When spacers or partials are required, mark the missing teeth with an "X" on the claim form.

ADA Block No.	*ADA Description Alabama Medicaid Use*	*Guidelines*
28	Tooth Surface	Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL, MODBL). The block is left blank for exams, X-rays, prophylaxis, fluoride, and crowns. M – Mesial F – Facial; Labial O – Occlusal L – Lingual or Cingulum D – Distal I – Incisal B —Buccal; Labial
29	Procedure Code	Enter the appropriate ADA procedure code(s) for the procedure(s) (such as D0120).
31	Fee	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
32	Other Fees	**Enter the amount paid by the other insurance or other third party sources known at the time of submission of the claim.**
33	Total Fee	Enter the total of the charges on the claim. **DO NOT SUBTRACT** the amount the other insurance pays (if applicable).
35	Remarks	The only information that should be written in this section is “TPL Denial Attached” and the date of the third party (other insurance) denial. Make sure the EOB denial statement is attached. NO OTHER comments should be written in this section.
38	Place of Treatment	Enter the following place of service codes in the appropriate box: office, hospital, or other: • 11 – Dental office • 21 – Inpatient hospital • 22 – Outpatient hospital • 31 – Skilled Nursing facility *****Use the "HOSP" box to indicate outpatient hospital or inpatient hospital.**
45-47	Treatment Results From	As applicable, indicate yes or no. If yes, provide date of accident and state (if auto accident).
48	Billing Dentist or Dental Entity	Enter the billing provider's name, street, city, state, and ZIP code. The billing (payee) name, address, Medicaid number is printed in the upper left corner of the Explanation of Payments (EOP). This information must be entered exactly as it reads on the EOP.
49	Provider ID	Enter the provider number of the **actual** dentist performing the service. Enter the rendering (performing) provider’s number. NOTE: If the billing provider (payee) entered in the License Number field at the bottom of the form is a group provider, the rendering (performing) provider must be a member of the group.

ADA Block No.	*ADA Description Alabama Medicaid Use*	*Guidelines*
50	License Number	This space is for the billing (payee) provider number. Enter the billing provider's nine-digit Alabama Medicaid provider number in the license number field. The billing (payee) number is the number printed in the upper left corner of the Explanation of Payments (EOP). The rendering (performing) provider number and the billing provider number may or may not be the same, but each number **must** be entered in the appropriate location.
52	Phone Number	Enter the office phone number should Medicaid staff need to contact staff for questions/information.
53	Treating Dentist Information	Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.